

A.R.S. § 43-210
APPLICATION FOR CERTIFICATE OF ELIGIBILITY FOR THE
HEALTH INSURANCE PREMIUM TAX CREDIT
INDIVIDUALS ONLY

Please Print

Individual Applicant First Name:		Last Name:	
Individual Applicant Address Number and Street or PO Box:			
City:		State	ZIP Code
Individual Applicant Day-Time Phone Number			
Family size (Total # - self, spouse and dependent children)			
Check one: <div style="margin-left: 40px;"><input type="checkbox"/> Applying for Certification for Applicant Only. <input type="checkbox"/> Applying for Certification for Applicant's Dependent Child(ren) Only. Number of Dependent Children _____ <input type="checkbox"/> Applying for Certification for Applicant plus Family (spouse or spouse and children)</div>			
Gross Yearly Income \$			
Check one: <div style="margin-left: 40px;"><input type="checkbox"/> I am a legal resident of Arizona and a citizen of the United States. <input type="checkbox"/> I am a legal resident alien living in Arizona.</div>			

I have completed this application. I declare that to the best of my knowledge and belief, this information is true, correct and complete. I also declare that I have not been covered under a health insurance policy for at least six consecutive months prior to this application and I am not currently enrolled in the Arizona Health Care Cost Containment System (AHCCCS), Medicare or any other state or federal government health insurance program.

Signature

Date

This application should be mailed to the following address:

Georganna Meyer, Chief Economist
Office of Economic Research and Analysis
Arizona Department of Revenue
PO Box 25248
Phoenix, AZ 85002

If you have questions regarding completion of this form, contact Georganna Meyer at (602) 716-6927.